DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Mr. Richard Allen
Director, Office of Medical Assistance
Department of Health Care Policy and Finance
1573 Street
Denver, CO 80203-1714

Dear Mr. Allen:

We are happy to inform you that your request for an amendment of the demonstration entitled "Alternatives in Medicaid Home Care"(AMHC) Demonstration has been approved. The demonstration was originally approved on October 15, 1997 as project No. 11-W-00073/8, but was not implemented. This approval is under the authority of section 1115 of the Social Security Act.

The amendment is requested to allow for the altered client eligibility criteria with a parameter of 50 or more skilled nursing visits and 230 or more home health aide visits in the prior years of home health utilization. Also, as requested, the budget neutrality agreement and. time period for the demonstration is updated.

Our approval of the amendment for the AMHC Demonstration (and the waivers and Federal matching authority for there under) is contingent upon compliance with the enclosed revised special terms and conditions. The special terms and conditions set forth in detail the nature, character, and extent of anticipated Federal involvement in this project: The award is subject to our receiving your written acceptance of the amendment approval within 30 days of the date of this letter.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable to this letter, shall apply to the AMHC Demonstration. Subject to approval of your protocol, as described in the special terms and conditions, the following waivers are granted pursuant to the authority of section 1115(a) for a period of 5 years beginning with the enrollment of the first demonstration participant.

Statewideness 1902(a)(1) of the Act

To enable the State to implement the demonstration in certain specified areas of the State.

2. Freedom of Choice of Provider 1902(a)(23) of the Act.

   To enable the State to select a limited number of certified home health agency providers to participate in the demonstration project.

3. Amount, Duration and Scope 1902(a)(10)(B) of the Act.

To enable the State to provide to demonstration participants demonstration services that are not equal in amount, duration, and scope for all recipients within the group.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State of Colorado under the AMHC Demonstration for the items identified below (that are not otherwise included as expenditures under section 1903) shall, for the period of the project be regarded as expenditures under the State's Title XIX plan.

Expenditures for demonstration services, which do not meet the definition of home health services, insofar as these services are provided outside the home to demonstration participants.

2. Expenditures for demonstration services that are not otherwise State Plan services e.g., nurse monitoring visits as the need arises.

Your project officer is Sandy Khoury who may be reached at (410) 786-8066. She is available to answer any questions concerning the scope and implementation of the demonstration. Communications regarding program matters, and. official correspondence concerning the demonstration (including continuation applications), should be submitted to the project officer at the following address: Center for Medicaid and State Operations, Centers for Medicate and Medicaid Services, Mail Stop $2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

We extend our congratulations on this award and look forward to working with you during the course of the demonstration.

Sincerely,

Thomas A. Scully

Enclosure

TERMS AND CONDITIONS
**Modified** June 2001

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## L PREFACE

The following arc Special Terms and Conditions for the award of the Colorado Medicaid Section 1115 Program request submitted on June 2, 1995. The Special Terms and Conditions have been arranged into six broad subject areas: General Conditions for Approval, Legislation, Assurances/Definitions, Genera] Financial Requirements, Monitoring Budget Neutrality, and Operational Protocol.

Letters, documents, reports, or other materials that are submitted for review or approval will be sent to the Health Care Financing Administration (HCFA) Central Office Colorado demonstration Project Officer and the Colorado State representative in the HCFA Regional Office.

## II. GENERAL PROGRAM CONDITIONS

1. Operational Protocol The State must prepare one Operational Protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA during the course of the demonstration negotiation, approval, and implementation process. The Operational Protocol, as outlined in Section VI of these Special Terms and Conditions, must be approved by HCFA prior to service delivery under the demonstration. The Operational Protocol must contain descriptive and operational aspects of the program to include information, as appropriate, about, at least: the State's organizational structure in place to operate the program, eligibility criteria for the demonstration, eligibility determination procedures, marketing plans and procedures, excluded services, financial responsibilities of enrollees, the State's research and demonstration/evaluation approach and method, and the procedures that the State must utilize to report expenditures and program status. The protocol must be submitted to HCFA no later than 90 days prior to program implementation. HCFA will respond within 60 days of receipt of the protocol regarding any issues or areas that it believes to require clarification.

2. Prior Approval of Marketing and Enrollment Information. Marketing materials and enrollment information must be reviewed and approved by HCFA prior to use. The State may do this by submitting numbers 3 and 4 of Section VI prior to submitting the entire Operational Protocol document, if needed.

**Operational Protocol** Approval Prior to Federal Financial Participation. No FFP will be provided for Medical Assistance Payments under the section 1115 program until HCFA has approved the Operational Protocol. Federal Financial Participation will be available for project development and implementation, and compliance with Special Terms and Conditions.

Changes to the Operational Protocol. During the demonstration, subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by HCFA. The State must submit a request to HCFA for these changes no later than 90 days prior to the date of implementation of the change(s).

Phase-out Plan. The State must submit a phase-out plan of the demonstration to HCFA 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of enrollees should the demonstration be extended by HCFA. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to HCFA review and approval

**Enrollment limitation** During the **Last Six Months.** During the last 6 months of the demonstration, new enrollment is not permitted unless the demonstration authority is extended by HCFA.

**Cooperation with** Federal Evaluators. The State must fully cooperate with Federal evaluators and their contractor's efforts if HCFA conducts an independent Federally-funded evaluation of the demonstration program, which may include the establishment and mutual agreement on a comparable control group.

HCFA **Right to Terminate or Suspend.** HCFA may suspend or terminate any project **in** whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. HCFA will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its fights under 42 CFR 430, Grants to states for Medical Assistance Programs, to challenge HCFA's finding that the State materially failed to comply. HCFA reserves the right to withhold waivers pending or to withdraw waivers at any time if it decides that granting or continuing the waivers would no longer be in the public interest. If the waiver is withdrawn, HCFA will be liable for only normal close-out costs.

**State Right to** Terminate or Suspend. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify HCFA in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, HCFA will be liable for only normal close-out costs.

## IIL GENERAL REPORTING REQUIREMENTS

**Progress** Calls and Reports. Prior to implementation and until 6 months after implementation HCFA and the State must hold monthly calls to discuss progress. During the remainder of the demonstration, progress calls will be held quarterly, however, HCFA will be available for additional calls as merited. Further, the State must submit quarterly progress reports that are due 60 days after the end of each quarter. The reports must include, as appropriate, a discussion of events occurring during the quarter that affect program operations, including: enrollment and outreach activities; access and quality monitoring; complaints, grievances, and appeals to the State; numbers of demonstration enrollees; and other operational and policy issues. The report must also include proposals for addressing any problems identified in each report. The State must include a discussion of the content and frequency of these reports in the Operational Protocol (see Section

11. Annual Reports. The State must submit a draft annual report documenting accomplishments, project status, quantitative and any case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from HCFA, a final annual report will be submitted. The State must include a discussion of the content and frequency of these reports in Operational Protocol (see Section VI).

Final Report. At the end of the demonstration, a draft final report must be submitted to HCFA for comments. HCFA's comments shall be taken into consideration by the State for incorporation into the final report. HCFA's document *author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 90 days after the termination of the project.

## IV. LEGISLATION

**Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, will apply to the Demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, HCFA will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that arc or are not affected by the Colorado Demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the Demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

**Changes in Medicaid Law**. The State must, within the time flame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect state Medicaid spending in the absence of the demonstration, HCFA will incorporate such changes into a modified budget limit for the Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the Demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to HCFA for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in New Hampshire, HCFA would approve the methodology. Should HCFA and the State, working in good faith to ensure state flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

**Amending the Demonstration**. The State may submit to HCFA a request for an amendment to the Demonstration program to request exemption from changes in law occurring after the waiver award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified Demonstration program do not exceed projected expenditures in the absence of the Demonstration (assuming full compliance with the change in law).

## ASSURANCES/DEFINITIONS

**Adequacy of** Infrastructure. Assurance that per 42 **CFR 484.36(d)(1) and (2),** clients receiving skilled nursing services also receive a supervisory visit no less than once every
2 weeks. However, per 42 CFR 484.36(d)(3), clients receiving only home health aide services (in the absence of skilled nursing care) must receive a supervisory visit by a registered nurse at least once every 62 days. Under this demonstration, home health aide services are defined to include those services that have been delegated to aides by registered nurses. As such, home health aide services, regardless of

whether these services have been delegated by a registered nurse, require supervision by a registered nurse at least every 62 days, but will not be subject to the 2-week supervisory requirement for skilled nursing care so long as only non-skilled nursing (aide) services are being received/provided.

Assure that there are sufficient duly qualified home health agencies and home health aides to adequately serve the project's expected enrollment. No FFP will be provided until HCFA is assured that provider capacity under the demonstration is acceptable.

Protection **of Confidentiality and Informed Consent.** Assure, as part of the enrollment process, that eligible that wish to participate in this demonstration project give consent to participate. Such informed consent includes that enrollees are aware of: (1) the voluntary nature of their participation in the demonstration; and (2) how the provision of health care will be modified as a result of the demonstration design. The State may include such necessary information on an enrollment form. However, any forms to be used for this purpose must be submitted to the HCFA project officer for review and approval.

**Assure the Continuation of** Other Traditional **Programs of** Care. Home health services provided under this demonstration program do not supplant other services or programs that are available to the client. Services provided through the Department of Education under entitlement of the Individuals with Disabilities Education Act, Part H, are not being supplanted/replaced by this project. Also individuals with End State Renal Disease (ESRD) will not be precluded from participating in this program, although ESRD-specific home health services are not be provided as a part of this demonstration project.

19. Staffing. Staff and resources will be made available to prepare the Operational Protocol (See Section VI.)

VI. OPERATIONAL PROTOCOL

Operational Protocol Content. The State must develop a detailed protocol describing the demonstration. The protocol will serve as a stand-alone document that reflects the operating politics and administrative guidelines of the demonstration. The protocol will be submitted for review and approval no later than 90 days prior to implementation. HCFA will respond within 60 days of receipt of the protocol. The State must assure and monitor compliance with the protocol. The protocol must encompass all requirements specified in the Special Terms and Conditions, including:

Organization and Structural Administration. A 'description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details about claims processing, dispensing, participant cost sharing collections, and other such details.

2) **Reporting Items. A** description of the content and frequency of each reporting item as listed in Section II and III, and Attachment A of this document.

Outreach/Marketing. A description of the State's outreach, marketing, and staff training strategy, including: information that will be communicated to providers, potential demonstration clients, and State outreach/education/intake staff (such as social services workers and caseworkers); types of media to be used; specific geographical areas to be targeted; locations where such information will be disseminated; staff training schedules; schedules for State forums or seminars to educate the public; and the availability of bilingual materials/interpretation services and services for individuals with special needs.

Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (include the eligibility criteria for inclusion and exclusion). Describe the processes for eligibility

determination, intake, enrollment, and disenrollment; and the State Agency that will be responsible for each of these processes.

Enrollment Limit. Identify the enrollment limit and any process for revising the limit. Also include a description of the procedure for establishing and maintaining waiting lists for participants in the demonstration.

Benefits. Descriptions or listings must be included for Alternative Health-Related Services which may be approved for participants, as well as procedures for amending the description of services.

Skilled Care. The operational protocol must also provide a clarification of the differences in eligibility requirements for skilled care under the State's Medicaid prepare, and eligibility requirements for skilled care under Medicate, as well as a discussion of the circumstances and guidelines under which a dually-eligible client would be switched to Medicate as primary payor for skilled nursing care. These guidelines should include details regarding how and for what services Medicate will be billed, how the State will be informed that Medicate has made payment for specific services, and how the State will determine which services are not covered under Medicate. Include the listing of the nursing functions that will be delegated to home health aides, along with the guidelines and criteria to be utilized in selecting tasks that can be delegated.

**Education, Counseling,** Fiscal Intermediary **(FI) and Support Services.** Descriptions of the following topics must be included:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, and training,

Quality. Description of an overall quality assurance monitoring plan that includes, but not be limited to the following:

- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
- plans to provide for an annual survey for each participating provider (home health agency), as well as satisfaction surveys to patients, nurses and home health aides;

- plans to designate a single staff member (or a very limited number of staff members) for persons to contact with either patient-level or agency issues/concerns;
- procedures for assuring quality of care and participant safeguards;
- procedures for insuring against duplication of payment between the CDAS and AMHC demonstrations, for service and Home and Community-Based Services programs; and
- fraud control provisions and monitoring.

10) Evaluation Design. A description of the State's evaluation design, including: a discussion of the demonstration hypotheses that will be tested; outcome measures that will be included to evaluate the impact of the demonstration; what data will be utilized; the methods of data collection; how the effects of the demonstration will be isolated from other initiatives occurring in the State; and any other information pertinent to the State's evaluative or formative research via the demonstration operations.

## ATTACIIMENT A GENERAL FINANCIAL REQUIREMENTS

The State must provide quarterly expenditure reports using the form HCFA-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. The Health Care Financing Administration (HCFA) will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B ('Monitoring Budget Neutrality for the demonstration).

In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine HCFA-64 reporting transactions outlined in Section 2500 of the State Medicaid Manual. Applicable rebates and expenditures subject to the budget neutrality cap will be reported on separate forms HCFA-64.9WAIV and/or 64.9PWAIV, identified by the demonstration project number assigned by HCFA (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements must be recorded on line 10.b, in lieu of lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of demonstration participants, and those individuals eligible to participate (as described in number 3.c. and d. of this section) that are also receiving the services subject to the budget neutrality cap. The services subject to budget neutrality include: Home and Community-Based Services, Personal Care; Nursing; Home Health Aide; and Homemaker.

For each demonstration year a form HCFA-64.9WAIV and/or 64.9PWAIV will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The services must be reported on a date of service basis. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2 c.).

Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration
period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the form HCFA-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VI.)

For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to HCFA on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information must be provided to HCFA in conjunction with the quarterly progress report referred to in number 10 of Section I'll. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section VI.).

The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

The demonstration Medicaid eligibility group (MEG) consists of persons residing in the geographic service areas under the demonstration who are using home health agency (HHA) services and for 12 months have utilized at least one service per month.

The term "demonstration eligibles" refers to persons who are eligible in the geographic areas of the demonstration and receiving services subject to the budget neutrality cap, whether or not they are participants of the features of the demonstration.

The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form HCFA-37. As a supplement to the form HCFA-37, the State must provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of this Attachment. HCFA will make Federal funds available based upon the State's estimate, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the form HCFA-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the annual grant award to the State.

5. HCFA will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for he following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.

c. Net medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State must certify state/local monies used as matching funds for the Colorado demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B
MONITORING BUDGET NEUTRALITY **FOR** THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the AMHC and CDAS demonstrations. The demonstrations will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, the State must be at risk for the per capita cost (as determined by the method described below) for Medicaid-eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, HCFA will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid-eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. There will be one budget limit for both AMHC and CDAS. Procedures for accommodating the potentially different time periods for each demonstration must be included in the Operational Protocol.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

**Projecting Service Expenditures**

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to HCFA by the State under the guidelines set forth in Attachment A number 3.a. The State Fiscal Year (SFY) 2000 base year cost is $31,966.46 (or $ 2,663.87 monthly per person cost) and the trended amounts by SFY are the following:

| State Fiscal Year | Trended Monthly Per Person Cost |
|---|---|
| SFY 2002 | $ 3,385.86 |
| SFY 2003 | $ 3,817.22 |
| SFY 2004 | $ 4,303.53 |
| SFY 2005 | $ 4,851.80 |
| SFY 2006 | $ 5,469.92 |
| SFY 2007 | $ 6,166.79 |

Demonstration Years which do not align with SFYs or which fall beyond the range of years shown must be calculated using an annual trend rate of 12.74 percent or a monthly equivalent growth rate of 1.0043 percent.

Using the trend rates to produce non-Federal fiscal year PMPM cost estimates

Because the beginning and the end of the demonstration are unlikely to coincide with either the Federal or state fiscal year, the following methodology will be used to produce DY estimates of PMPM cost. Using the monthly equivalent growth rate, the appropriate number of monthly trend factors will be used to convert SFY *2000* base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations

First Demonstration Year:

As an example, assume that the base year (SFY 2000) per capita cost for the enrolled population is $1,000, and the first year of a demonstration (DY 2001) is January I, 2001, and ends December 31, 2001. DY 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward DY to 2001. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PMPM cost of $1079 ($1079 = $1000 x 1.00423336s).

Second and Subsequent Demonstration Years:

Since DY 2001 is 12 months beyond DY 2002, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PMPM cost of $ I079 gives a DY 2002 PMPM cost orS1135.

**I- How the limit will be applied**

The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients ,and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

**Expenditure Review**

HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, HCFA will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to HCFA for approval. The State must subsequently implement the approved program.

| Year | Cumulative target definition | Percentage |
|---|---|---|
| Year I | Year l budget neutrality cap plus | 8 percent |
| Year 2 | Years I and 2 combined budget neutrality cap plus | 3 percent |
| Year 3 | Years 1 through 3 combined budget neutrality cap plus | l percent |
| Year 4 | Years I through 4 combined budget neutrality cap plus | 0.5 percent |
| Year 5 | Years 1 through 5 combined budget neutrality cap plus | 0 percent |

## MONITORING ACTIVITIES

The Health Care Financing Administration (HCFA) reserves the fight to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.

During the developmental phase of the demonstration, the awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

No later than 60 calendar days from receipt of this award, the awardee must provide a complete plan to phase-down and phase-out the demonstration. At a minimum, this plan must include the manner in which beneficiaries will be shifted to other sources of care or be told of the cessation of the demonstration. The awardee may not begin the delivery of services in this demonstration until this plan has been received and approved by the project officer. If assistance is needed, the project officer is prepared to discuss the expected content.

## FINANCIAL REPORTING REQUIREMENTS

4. The awardee shall submit the following forms for the demonstration on a quarterly basis to your State's Medicaid office. Submit only one set of HCFA-64's for the project.

HCFA-64.9
HCFA-64.9p
HCFA-64.10
HCFA-6,. 10p
HCFA-64.9a
HCFA-64.9o
HCFA-64 Certification
HCFA-64 Summary

Report all administrative and service expenditures allowed under the waivers approved for this demonstration. Do not include expenditures related to research and evaluation activities.

## REPORTING REQUIREMENTS

5. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted.

The awardee shall submit quarterly progress reports, which are due 30 days after the end of each quarter. The first quarterly report is due on [30 DAYS AFTER END OF FIRST QUAINTER]. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, financial results, and other operational issues.

The awardee will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of the each award year. Within 30 days of receipt of comments from OR-D, a final annual report will be submitted.

A final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Fin. al Reports (copy attached) in the preparation of the final report. The final report shall be submitted to the HCFA Grants Officer and the HCFA Project Officer no later than 90 days after the completion of the project.

The final report of the project may not be released or published without permission from the HCFA project officer within the first 4 months following the receipt of the report by the HCFA project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and that the report does not/do not necessarily reflect the opinions of HCFA.

For 2 years after completion of the project, the awardee shall notify the HCFA project officer prior to formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the HCFA project officer before formal dissemination to the general public.

## DATA REQUIREMENTS

At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, shall submit copies of analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by HCFA. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the HCFA project officer. The negotiated format(s) could include both file(s) that would be limited to HCFA internal notes and file(s) that HCFA could make available to the general public.

## OTHER REQUIREMENTS

Within 30 days of the date of approval, the State shall develop and submit a detailed schedule depicting milestone activities (including sub-tasks), project reports, and deliverables to be completed during the demonstration (including both the pre-implementation and implementation periods). The State must provide adequate assurances that all preliminary milestone activities (i.e., during the pre-implementation period) will be completed prior to the project's implementation period.

The State shall prepare an Operational Protocol that details the management and operational features of the demonstration, expanding on the proposal and incorporating activities and decisions made during the developmental phase of the demonstration. The protocol must be submitted and approved by the HCFA project officer before implementation of the demonstration. The protocol shall detail:

assignment of oversight and management responsibilities;
ongoing monitoring tasks, and State personnel responsible for specific oversight functions; provisions for determining eligibility; enrollee grievance and appeal rights; description of the State's relationships and arrangements with participating home health agencies; service delivery, plan; financial management plan; marketing strategy, and provisions for enrollee education; provisions for enrollment and disenrollment; description of payment arrangements; quality assurance plan; data collection and reporting plan, and associated requirements for participating home health agencies; and phase-down plan.

The operational protocol should also provide a clarification of the differences in eligibility requirements for skilled care under the State's Medicaid program, and eligibility requirements for skilled care under Medicate, as well as a discussion of the circumstances and guidelines under which a dually-eligible client would be switched to Medicate as primary payor for skilled nursing care. These guidelines should include details regarding how and for what services Medicate will be billed, how the State will be informed that Medicate has made payment for specific services, and how the State will determine which services are not covered under Medicate.

Prior to project implementation, the State shall develop a quality assurance plan for this project which provides for an annual survey for each participating provider (home health agency), as. well as satisfaction surveys to patients, nurses, and home health aides. The State shall also designate a single staff` member (or a very limited number of staff` members) for persons to contact with either patient-level or agency issues/concerns.

The quality assurance plan developed shall demonstrate a Continuous Quality Improvement focus, and shall require agencies to undertake a specific Corrective Action Plan (CAP) when deficiencies are identified. The State will also develop a CAP when client surveys reveal potential problems. In addition, annual quality assurance reports will be prepared and submitted to the HCFA project officer.

Prior to project implementation, the State shall develop and submit to HCFA a listing of the nursing functions that will be delegated to home health aides, along with the guidelines and criteria to be utilized in selecting tasks which can be delegated. The State will also provide an explanation of why it believes these guidelines/criteria are justified.

Per 42 CFR 484.36(d)(1) and (2), clients receiving skilled nursing services must also receive a supervisory visit no less than once every 2 weeks. However, per 42 CFR 484.36(d)(3), clients receiving only home health aide services (in the absence of skilled nursing care) must receive a supervisory visit by a registered nurse at least once every 62 days. Under this demonstration, home health aide services are defined to include those services which have been delegated to aides by registered nurses. As such, home health aide services, regardless of whether these services have been delegated by a registered nurse, will require supervision by a registered nurse at least every 62 days, but will not be subject to the 2-week supervisory requirement for skilled nursing care so long as only non-skilled nursing (aide) services are being received/provided.

The State and its subcontractors shall agree to participate in an independent evaluation of the project. The State shall provide 2 years of historical data and data throughout the demonstration, including individual level data, as specified by HCFA.

As a part of the enrollment process, the State will obtain signed informed consent from beneficiaries who wish to participate in this demonstration project. Such informed consent will assure that ¢enrollees arc

aware of: (1) the voluntary nature of their participation in the demonstration; and (2) how the provision of health care will be modified as a result of the demonstration design. The State may include such necessary information on an enrollment form. However, any forms to be used for this purpose must be submitted to the HCFA project officer for review and approval.

Prior to the beginning of the demonstration's operational phase, the State must submit evidence that there arc sufficient duly qualified home health agencies and home health aides to adequately serve the project's expected enrollment. No FFP will be provided until HCFA supplies written approval that provider capacity under the demonstration is acceptable. At least 30 days before the start of the demonstration's operational phase, copies of model provider agreements with participating home health agencies shall be provided to HCFA for review and comment.

Using current State guidelines on readability and accuracy, the State will approve all direct marketing material used by home health agencies to enroll Medicaid clients before such marketing materials are disseminated under the demonstration. Direct marketing material is defined as marketing materials in all media, including brochures and leaflets, newspaper, magazine, radio, television, billboard, and yellow page advertisements, and presentation materials used by marketing representatives. In addition, it includes State-developed materials mailed to, distributed to, or aimed at Medicaid recipients, and any material that mentions Medicaid, Medical Assistance, or Title XIX. HCFA reserves the right to review copies of State or home health agency marketing materials and to require modifications prior to dissemination if deemed necessary.

The primary purpose of this project is to evaluate the independent care model. This demonstration has therefore been designed to assist individuals who are capable of directing their own care. However, children and persons with cognitive impairments such as Alzheimer's disease (i.e., individuals not capable of directing their own care) wig not be deliberately excluded from participating in the demonstration. Specifically, individuals requiring the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

Home health services provided under this demonstration program are not intended to supplant other services or programs that are available to the client. Services provided through the Department of Education under entitlement of the Individuals with Disabilities Education Act, Part H, will not be supplanted/replaced by this project. Also individuals with End State Renal Disease (ESRD) will not be precluded from participating in this program, although ESRD-specific home health services will not be provided as a part of this demonstration project.

## BUDGET NEUTRALITY REQUIREMENTS

The following describes the method by which budget neutrality will be assured under the State of Colorado's proposed home health section 1115 waiver demonstration project, Alternatives in Medicaid Home Care Demonstration.

Colorado will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. OMB will calculate this limit using a per capita cost method. In the base year, Federal fiscal year 1996, we will divide the total Medicaid home health costs for people who used 230 or more home health aide visits and 110 or more skilled nursing visits in fiscal year 1996 by the total number of people in this category. In this way, Colorado will be at risk for the per capita cost for Medicaid-eligibles, but not at risk for. the number of eligibles. By placing Colorado at risk for the per capita costs of Medicaid-eligibles, HCFA assures that the demonstration expenditures do not exceed the *levels* that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates on a per capita basis will be calculated for each year on a demonstration year (DY) basis.

The annual estimates will then be added together to obtain a per capita expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for home health services provided under this demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Projected per-member-per-month (PMPM) costs in each demonstration year will be calculated by using a trend factor to convert base year per capita costs into current year projected per capita costs for each year of the demonstration. At OMB's discretion, the trend factor will be based on either historical costs or on a national trend rate. OMB will make this decision after reviewing the historical data. Colorado cannot begin enrollment into the project until this decision has been made.

Colorado will be responsible for ensuring that the demonstration participant population, on average, used over 130 home health aide visits in the year prior to their enrollment in the demonstration. Colorado will be responsible for ensuring that the demonstration participants, on average, used over 61 skilled nursing visits in the year prior to their enrollment in the demonstration.

**Expenditure** Review -- HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, HCFA will calculate the actual spending in the absence of the demonstration for the completed year. This amount will be compared with the actual Federal financial participation claimed by the State under budget neutrality for this demonstration. No later than 6 months after the end of each demonstration year, Colorado will submit to HCFA, for review, the home health care utilization of each demonstration participant. Utilization data will be provided both for the period of the participant's enrollment in the demonstration, and for the 12-month period to their enrollment in the demonstration. HCFA will calculate the average home health care use of these demonstration participants. Using the schedule below as a guide, if the State exceeds baseline expenditures (i.e., in the absence of the demonstration), or drops below the average home care use target, they shall submit a corrective action plan to HCFA for approval. The State will subsequently implement the approved program. For example, if in Year 01 of the demonstration, the State exceeds either the Year 01 budget neutrality cap by more than eight percent or drops below the home health care use lower limit by eight percent, the State must submit a corrective plan of action.

| Year | Cumulative Baseline in the Absence of the Demonstration or Home Care Use Target | Percentage |
|---|---|---|
| Year 1 | Year 1 | 8 percent |
| Year 2 | Years 1 and 2 combined | 3 percent |
| Year 3 | Years 1 through 3 combined | 1 percent |
| Year 4 | Years 1 through 4 combined | 0.5 percent |
| Year 5 | Years 1 through 5 combined | 0 percent |

**The demonstration may not be implemented until the State has submitted the following data, and the per capita baseline limits (in the absence of the demonstration) have been calculated:**

As with all 1115 waiver demonstrations, OMB requests 4 years of historical cost data. These data are frequently, but not always, used to determine the trend factor by which base year costs are projected for the duration of the demonstration. Colorado should provide Statewide PMPM Medicaid home health care costs for the 4 most recent years for which cost data are available, and the total of member months per recipient for whom 230 or more home health aide visits and 110 or more skilled nursing visits were delivered.

This grant/cooperative agreement incorporates the following terms and conditions by reference with the same effect as if they were given in full text.

**45 CFR Part 92 Terms and Conditions Incorporated by Reference**

| | |
|---|---|
| 92.30 | Changes |
| 92.34 | Copyrights |
| 92.43 | Enforcement |

Termination for Convenience

| | |
|---|---|
| **92.50** | Closeout |

**Public Law 103.333 Department of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act of 1995**

**Section 507**
To the greatest extent practicable, all equipment and products purchased by the awardee and its subcontractors, with Federal and matching funds, should be American-made.

**Section 508**
The awardee, when issuing statements, press releases, requests for proposals, bid solicitations, and other documents (including reports, published articles, findings and other results) concerning this project, shall dearly state: (1) the percentage of the total cost of the project finance with Federal money; (2) the dollar amount of Federal funds for the project; and, (3) the percentage and dollar amount of the total costs of the project financed by nongovernmental sources.